Application Template for Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Proposal

The State of Colorado, Department of Health Care Policy and Financing proposes a section 1115 demonstration entitled Adult Prenatal Coverage in CHP+, which will increase the number of individuals with health insurance coverage.

I. General Description of Program

The Adult Prenatal Coverage in CHP+ demonstration, which is scheduled to begin on July 1, 2002, will provide health insurance coverage to an additional 13,000 residents of the State of Colorado with incomes at or below 185% of the Federal poverty level. The increased coverage will be funded by Colorado's S-CHIP allotment and other available state funds, which have been appropriated by the General Assembly for the State Fiscal Year beginning July 1, 2002.

II. Definitions

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments.)

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

__√__ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

__√__ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.

__√__ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

__√__ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

__√__ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

__√__ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

IV. STATE SPECIFIC ELEMENTS

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is **one hundred eighty-five** percent of the FPL.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations (as specified in Title XIX.)

_____ Section 1931 Families

_____ Blind and Disabled

_____ Aged

_____ Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

_____ Children and pregnant women covered in Medicaid above the mandatory level

_____ Parents covered under Medicaid

_____ Children covered under SCHIP

_____ Parents covered under SCHIP

_____ Other (please specify)

Medically Needy

_____ TANF Related

_____ Blind and Disabled

_____ Aged

_____ *Title XXI children (Separate SCHIP Program)*

_____ *Title XXI parents (Separate SCHIP Program)*

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.)

Populations that can be covered under a Medicaid or SCHIP State Plan

_____ Children above the income level specified in the State Plan
This category will include children from _____percent of the FPL through _____percent of the FPL.

_____ Pregnant women above the income level specified in the State Plan

This category will include individuals from _____percent of the FPL through _____percent of the FPL.

_____ Parents above the current level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

_____ Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

_____ Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

_____ Other. Please specify:_____

_____

_____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the new HIFA demonstration.

_____ Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

__√__ Pregnant Women in SCHIP (This category will include individuals from **134** percent of the FPL through **185** percent of the FPL.)

_____ Other. Please specify: _____

_____

_____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

_____ No

__√__ Yes

(If Yes) Number of participants
or dollar limit of demonstration:

The program cap will be based upon the lesser of the:
annual appropriation made by the Colorado General Assembly for the expansion program; or
available federal allotment, plus any reallocated funds minus the base CHP+ program costs

(Express dollar limit in terms of total computable program costs.)

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased in.

__√__ The HIFA demonstration will be implemented at once.

_____ The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline):_____
_____
_____
_____.

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

_____ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

2. Optional populations included in the existing Medicaid State Plan

_____ The same coverage provided under the State's approved Medicaid State plan.
_____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

_____ The same coverage provided under the State's approved Medicaid State plan.
_____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

2. New optional populations to be covered as a result of the HIFA demonstration

_____ The same coverage provided under the State's approved Medicaid State plan.
_____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations – States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included.

__√__ Inpatient

__√__ Outpatient

__√__ Physician's Surgical and Medical Services

__√__ Laboratory and X-ray Services

__√__ Pharmacy

__√__ Other (please specify): **Please see Attachment C.**

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private health insurance coverage	Group health plan coverage	Other (specify)
Mandatory					
Optional – Existing					
Optional – Expansion					
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP					
Existing section 1115 expansion					
New HIFA Expansion		√			

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

____ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

____ The same coverage provided under the State's approved Medicaid plan.

____ The same coverage provided under the State's approved SCHIP plan.

____ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees.

____ A benefit package that is actuarially equivalent to one of those listed above (please specify).

____ Secretary-Approved coverage.

____ Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)

____ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

____ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory		[redacted]	[redacted]
Optional – Existing (Children)			[redacted]
Optional – Existing (Adults)			
Optional – Expansion (Children)			[redacted]
Optional _ Expansion (Adults)			
Title XXI – Medicaid Expansion			[redacted]

Title XXI – Separate SCHIP			
Eligibility Category	**Nominal Amounts Per Regulation**	**Up to 5 Percent of Family Income**	**State Defined**
Existing section 1115 Expansion			
New HIFA Expansion		√	

Cost-sharing for children
Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as 'child cost-sharing' for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost-sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

Please see Attachment F for response to this section.

The rate of uninsurance in your State for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project.

_____

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project:

Private Health Insurance Coverage Under a Group Health Plan

_____

Other Private Health Insurance Coverage _____

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)

_____

_____

SCHIP (please separately identify any premium assistance)

_____

Medicare _____

Other Insurance _____

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

_____ The Current Population Survey

_____ Other National Survey (please specify_____)

_____ State Survey (please specify_____)

_____ Administrative records (please specify_____)

_____ Other (please specify_____)

Adjustments were made to the Current Population Survey or another national survey.

_____ Yes _____ No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

_____ Yes _____ No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

Please see Attachment F for response to this section.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

__√__ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

_____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

_____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a

State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be $ 63,945,018 over its four year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable):

Title XIX:

____ **Statewideness 1902(a)(1)**

To enable the State to phase in the operation of the demonstration.

____ **Amount, Duration, and Scope 1902(a)(10)(B)**

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

_____ **Freedom of Choice 1902(a)(23)**
To enable the State to restrict the choice of provider.

Title XXI:

____ **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

____ **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

_____ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

_____ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

__√__ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

_____ Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

__√__ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

_____ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

_____ Attachment B: Detailed description of expansion populations included in the demonstration.

__√__ Attachment C: Benefit package description.

__√__ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

__√__ Attachment E: Detailed discussion of cost sharing limits.

__√__ Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

__√__ Attachment G: Budget worksheets.

_____ Attachment H: Additional waivers or expenditure authority request and justification.

__√__ Attachment I: State Legislative Authority.

IX. SIGNATURE

_____	____Karen Reinertson_____
Date	Name of Authorizing State Official (Typed)
	_____
	Signature of Authorizing State Official

Attachment C:
Benefit Package Description

The benefits to be offered through the Adult Prenatal Coverage in CHP+ waiver are consistent with those offered to the majority of Coloradoans through their employers. Benefits under this waiver are intended to remain consistent with commercial health insurance coverage requirements. Currently, the categories of services and limitations, as they are codified in 10-16-101, C.R.S. et seq., are:

	DESCRIPTION OF BENEFIT
EMERGENCY CARE AND URGENT/AFTER HOURS CARE	Covered.
EMERGENCY TRANSPORT/AMBULANCE SERVICES	Covered.
HOSPITAL/OTHER FACILITY SERVICES A. INPATIENT B. PHYSICIAN C. OUTPATIENT/ AMBULATORY	Covered.
ROUTINE MEDICAL OFFICE VISIT [1]	Covered.
LABORATORY AND X-RAY	Covered.
PREVENTIVE, ROUTINE, AND FAMILY PLANNING SERVICES	Covered. Same benefits as mandated under the Small Group Standard Health Benefit Plan, Colorado Division of Insurance Regulation 4-6-5 (e.g. immunizations, well-child visits and health maintenance visits.)
MATERNITY CARE Prenatal Delivery & inpatient well baby care[2]	 Covered. Covered. State law requires infant to be covered for first 31 days.

[1] Routine medical office visits includes physician, mid-level practitioner and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.

[2] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

	DESCRIPTION OF BENEFIT
MENTAL ILLNESS CARE A. NEUROBIOLOGICALLY-BASED MENTAL ILLNESSES[3] B. ALL OTHER[4] 1. INPATIENT[5] 2. OUTPATIENT	 Covered. Treated the same as any other health condition (e.g. there are no limits on the number of hospital days covered.) Limited coverage. 45 days of inpatient coverage with the option of converting 45 inpatient days into 90 days of day treatment services. Limited coverage. 20 visit limit.
ALCOHOL AND SUBSTANCE ABUSE	Limited coverage. 20-outpatient visit limit. Inpatient is not covered except for acute detox: maximum 5 days per episode.
PHYSICAL THERAPY, SPEECH THERAPY, AND OCCUPATIONAL THERAPY	Limited coverage. 30 visits per diagnosis per year.
DURABLE MEDICAL EQUIPMENT (DME)[6]	Limited coverage. Maximum $2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.
TRANSPLANTS	Limited coverage. Will include those transplants covered by the Small Group Standard Plan (Colorado Division of Insurance regulation 4-6-5), including liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are Medically Necessary and the facility meets clinical standards for the procedure. Coverage is no less extensive than the coverage for any other physical illness.
HOME HEALTH CARE	Covered.
HOSPICE CARE[7]	Covered.

[3] Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.
[4] All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV manual.
[5] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.
[6] DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devises applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the member is **not** covered.

	DESCRIPTION OF BENEFIT
PRESCRIPTION DRUGS	Covered. (includes expendable medical supplies for the treatment of diabetes)
KIDNEY DIALYSIS	Covered, only when Member is not eligible for Medicare.
SKILLED NURSING FACILITY CARE	Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.
VISION SERVICES	Limited coverage. Vision screenings are covered as age appropriate preventive care. $50 annual benefit for eyeglasses.
AUDIOLOGY SERVICES	Limited coverage. Hearing screenings are covered as age appropriate preventive care. Hearing aides covered for congenital and traumatic injury; maximum $800/year paid by plan.
INTRACTABLE PAIN	Covered. Included as a benefit with the medical office visit copay.
AUTISM COVERAGE	Covered. Included as a benefit with the medical office visit copay.
CASE MANAGEMENT	Covered, when Medically Necessary.
DIETARY COUNSELING /NUTRITIONAL SERVICES	Limited coverage. Formula for metabolic disorders, total parenteral nutrition, enterals and nutrition products, and formulas for gastrostemy tubes are covered for people with documented medical need. Documentation includes prior authorization, which lists medical condition including gastrointestinal disorders, malabsorption syndromes or a condition that affects normal growth patterns or the normal absorption of nutrition.
LIFETIME MAXIMUM	Not applicable.
DENTAL RELATED	Medical coverage in connection with treatment of the teeth or periodontium is excluded unless such treatment: is performed by a physician or legally licensed dentist, is begun within 72 hours after an accidental injury to sound natural teeth. Also not excluded (state mandate) is orthodontic and prosthodontic treatment for cleft lip or cleft palate for newborns.
PRE-EXISTING CONDITION LIMITATIONS	No pre-existing condition limitations.

[7] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Division of Insurance Regulation 4-2-8 as amended.

	DESCRIPTION OF BENEFIT
THERAPIES: CHEMOTHERAPY AND RADIATION	Covered. When received during a covered admission and billed as part of the facility service, therapy charges will be paid in the same manner as room expenses and other ancillary services. This provision shall not be interpreted as an exclusion of Chemotherapy and Radiation therapy when delivered in an outpatient setting.
EXCLUSIONS	Benefits covered by a no-fault auto policy or employers liability laws; care that is not medically necessary; cosmetic surgery; custodial care; educational training programs; experimental and investigational procedures; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under this plan; TMJ with no medical basis; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[8]; transplants except for those listed above; dental related services except for those listed above; and war.

[8] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries.

Attachment D:
Detailed Description of Private Health Insurance Coverage Options

In July 2001, the Department of Health Care Policy and Financing released a report entitled "Final Report of the Employer Buy-In Feasibility Study." The report focused on the feasibility of including an employer buy-in component to the CHP+ program. This report found that a program of this nature would not be cost-effective, even under the most optimistic scenario. The Department discussed with the authors of the report the feasibility of an employer buy-in component for the adult population that is included in the waiver. Again, the authors did not believe that it would be cost-effective. However, the Department is in the process of reviewing the feasibility of other options for coordination of private health insurance coverage for these and other populations and will provide the report and recommendations to CMS with the annual progress report for FFY '03.

Attachment E:
Detailed Discussion of Cost-Sharing Limits

The cost-sharing requirements for the Adult Prenatal Coverage in CHP+ waiver are intended to be consistent with those that are described in the Title XXI State Plan with the exception of the annual enrollment fee.

Currently, enrollees in the CHP+ program with incomes between 151% and 185% of the federal poverty level are required to pay an annual enrollment fee of $25 for a single eligible child and $35 for two or more eligible children. Children living in families at or below 150% of the federal poverty level are not required to pay an annual enrollment fee. The population described in this waiver request would not be required to pay an annual enrollment fee, regardless of income level. However, co-payments at the time of service would still apply and are currently as follows:

> For families with income at or below 150% of the federal poverty level, the co-payment will be:
>
> 1. Two dollars per office visit;
> 2. Two dollars per outpatient mental health or substance abuse visit;
> 3. One dollar per prescription;
> 4. Two dollars per physical therapy, occupational therapy or speech therapy visit;
> 5. Two dollars per vision visit;
> 6. Three dollars per emergency visit and urgent/after-hours visit.
>
> For families with income between 151% and 185% of the federal poverty level, the co-payment will be:
>
> 1. Five dollars per office visit;
> 2. Five dollars per outpatient mental health or substance abuse visit;
> 3. Three dollars per generic prescription;
> 4. Five dollars per brand name prescription;
> 5. Five dollars per physical therapy, occupational therapy or speech therapy visit;
> 6. Five dollars per vision visit;
> 7. Fifteen dollars per emergency visit and urgent/after-hours visit.

Co-payments will not apply to preventative services, such as: healthy newborn and newborn inpatient visits; routine examinations; laboratory tests; immunizations and related office visits. American Indians and Alaska Natives will be exempt from all cost-sharing requirements. The maximum cost-sharing will be 5% of annual income.

Attachment F:
Description of Uninsured and Prenatal Performance Plan

Insurance coverage rates for individuals under 200% of the federal poverty level are summarized in the table below. This estimate is based on a two-year merge of Current Population Survey (CPS) data for calendar years 1999 and 2000.

Individuals Under 200% FPL	Insured		Uninsured
	Private	Public*	
Age 18 and Under	32.48%	34.27%	33.25%
Age 19 - 64			
Males	39.86%	23.48%	36.65%
Females	38.72%	17.02%	44.26%
Age 65 and Over	36.63%	62.79%	0.58%

*public insurance includes coverage for individuals in the military.

In addition, the State of Colorado specifically monitors insurance coverage rates for women giving birth in the state. The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, population-based surveillance system designed to supplement vital records data and to generate state-specific perinatal health data. In the fall of 1996, the Colorado Department of Public Health and Environment was awarded a grant from the Centers for Disease Control and Prevention (CDC) to establish PRAMS in Colorado. Data collection for this system began in April of 1997. PRAMS data will assist Colorado in evaluating and improving services to women and infants so that poor pregnancy outcomes can be prevented.

Each month, a stratified random sample of infants 2-4 months old is selected from birth certificate records to comprise the PRAMS sample. The sample is stratified on the regions of residence (Denver Metro, Other Metro, and Rural) and birth weight (low and adequate) to ensure a large enough sample in the low birth weight and rural categories. Women are excluded from the sampling if they are not Colorado residents, are age 14 or younger, or experienced a multiple birth of four or more live born infants.

Women are first sent a letter describing the project and providing them an opportunity to refuse to participate. They are then mailed the survey, with up to two more copies sent to nonresponders. Trained interviewers call women who do not respond by mail and the survey may be completed over the phone. Women who indicate on the birth certificate that they are of Hispanic origin receive all mailings in both English and Spanish; in addition, the phone interview can be completed with a Spanish-speaking interviewer. They survey data from the respondents are weighted to represent all pregnancies among Colorado residents age 15 and older who deliver live born infants.

Based on information collected through PRAMS, the Department of Health Care Policy and Financing estimates that nearly 3,400 uninsured women would be eligible for the program per year. Initial estimates indicate that by the end of FFY 04, 95% of eligible women will be enrolled. In addition, the Department of Health Care Policy and Financing intends to use

PRAMS data to establish a baseline against which it can measure performance. Within the first year of the demonstration, the Department will contract with a consulting firm to assist the State in establishing an evaluation protocol that would include specific health outcome measures beyond the reductions in uninsurance rates described above.

Attachment G:
Budget Worksheets

Attachment G: Budget Worksheet

ATTACHMENT G: COLORADO BUDGET WORKSHEET AVAILABLE FEDERAL FUNDS	FFY 01 Base Year	FFY 02 Federal Fiscal Year 1	FFY 03 Federal Fiscal Year 2	FFY 04 Federal Fiscal Year 3	FFY 05 Federal Fiscal Year 4	Total
State's Allotment	$ 44,648,559	$ 34,266,951	$ 31,752,000	$ 31,752,000	$ 40,824,000	$ 183,243,510
Funds Carried Over From Prior Year(s)	$ 88,483,598	$ 91,679,576	$ 79,056,111	$ 60,337,409	$ 35,470,959	$ 355,027,653
SUBTOTAL (Allotment + Funds Carried Over)	$ 133,132,157	$ 125,946,527	$ 110,808,111	$ 92,089,409	$ 76,294,959	$ 538,271,163
Reallocated Funds (Redistributed or Retained that are Currently Available)	$ 11,526,654	$ 13,490,080	$ -	$ -	$ -	$ 25,016,734
TOTAL (Subtotal + Reallocated funds)	**$ 144,658,811**	**$ 139,436,607**	**$ 110,808,111**	**$ 92,089,409**	**$ 76,294,959**	**$ 563,287,897**
State's Enhanced FMAP Rate	65%	65%	65%	65%	65%	
COST PROJECTIONS OF APPROVED SCHIP PLAN						
Benefit Costs						
Insurance payments	$ -	$ -	$ -	$ -	$ -	$ -
Managed care	$ 28,085,260	$ 42,109,208	$ 55,749,182	$ 63,852,258	$ 72,872,690	$ 262,668,597
per member/per month rate @ # of enrollees	$ 71.87	$ 81.05	$ 92.28	$ 97.22	$ 101.20	
Fee for Service	$ -	$ -	$ -	$ -	$ -	$ -
Total Benefit Costs	**$ 28,085,260**	**$ 42,109,208**	**$ 55,749,182**	**$ 63,852,258**	**$ 72,872,690**	**$ 262,668,597**
(Offsetting beneficiary cost sharing payments)	$ 195,458	$ 268,966	$ 343,989	$ 373,935	$ 410,562	$ 1,592,910
Net Benefit Costs	**$ 27,889,802**	**$ 41,840,242**	**$ 55,405,193**	**$ 63,478,323**	**$ 72,462,128**	**$ 261,075,687**
Administration Costs						
Personnel	$ 397,566	$ 417,047	$ 435,429	$ 448,604	$ 462,510	$ 2,161,157
General administration	$ 536,056	$ 391,067	$ 287,138	$ 295,825	$ 304,996	$ 1,815,081
Contractors - Marketing, Outreach, Eligibility and Enrollment	$ 2,080,854	$ 1,358,492	$ 1,450,613	$ 1,625,526	$ 1,840,040	$ 8,355,525
Claims Processing	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ 1,099,406	$ 2,297,549	$ 2,299,657	$ 969,586	$ 876,127	$ 7,542,324
Total Administration Costs	**$ 4,113,882**	**$ 4,464,154**	**$ 4,472,838**	**$ 3,339,540**	**$ 3,483,672**	**$ 19,874,086**
10% Administrative Cap	$ 3,098,867	$ 4,648,916	$ 6,156,133	$ 7,053,147	$ 8,051,348	$ 29,008,411
Federal Title XXI Share	$ 20,802,395	$ 30,097,857	$ 38,920,720	$ 43,431,611	$ 49,364,770	$ 182,617,353
State Share	$ 11,396,747	$ 16,475,505	$ 21,301,300	$ 23,760,187	$ 26,991,592	$ 99,925,330
TOTAL COSTS OF APPROVED SCHIP PLAN	**$ 32,199,142**	**$ 46,573,362**	**$ 60,222,020**	**$ 67,191,798**	**$ 76,356,362**	**$ 282,542,683**
COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL						
Benefit Costs for Demonstration Population						
Insurance payments	$ -	$ -	$ -	$ -	$ -	$ -
Managed care	$ -	$ 4,106,380	$ 17,204,639	$ 19,870,854	$ 21,172,985	$ 62,354,858
per member/per month rate @ # of enrollees	$ -	$ 467.48	$ 477.92	$ 515.46	$ 539.62	
Fee for Service	$ -	$ -	$ -	$ -	$ -	$ -
Total Benefit Costs	**$ -**	**$ 4,106,380**	**$ 17,204,639**	**$ 19,870,854**	**$ 21,172,985**	**$ 62,354,858**
(Offsetting beneficiary cost sharing payments)	$ -	$ -	$ -	$ -	$ -	$ -
Net Benefit Costs	**$ -**	**$ 4,106,380**	**$ 17,204,639**	**$ 19,870,854**	**$ 21,172,985**	**$ 62,354,858**
Administration Costs						
Personnel	$ -	$ -	$ -	$ -	$ -	$ -
General administration	$ -	$ 65,363	$ 202,338	$ 25,194	$ 44,355	$ 337,249
Contractors - Marketing, Outreach, Eligibility and Enrollment	$ -	$ 88,522	$ 362,227	$ 391,397	$ 410,764	$ 1,252,910
Claims Processing	$ -	$ -	$ -	$ -	$ -	$ -
Other (specify)	$ -	$ -	$ -	$ -	$ -	$ -
Total Administration Costs	**$ -**	**$ 153,884**	**$ 564,565**	**$ 416,591**	**$ 455,120**	**$ 1,590,159**
10% Administrative Cap	$ -	$ 456,264	$ 1,911,627	$ 2,207,873	$ 2,352,554	$ 6,928,318
Federal Title XXI Share	$ -	$ 2,769,172	$ 11,549,982	$ 13,186,839	$ 14,058,268	$ 41,564,261
State Share	$ -	$ 1,491,092	$ 6,219,222	$ 7,100,606	$ 7,569,837	$ 22,380,757
TOTAL COSTS FOR DEMONSTRATION	**$ -**	**$ 4,260,264**	**$ 17,769,204**	**$ 20,287,445**	**$ 21,628,105**	**$ 63,945,018**
TOTAL PROGRAM COSTS (State Plan + Demonstration)	**$ 32,199,142**	**$ 50,833,626**	**$ 77,991,223**	**$ 87,479,243**	**$ 97,984,467**	**$ 346,487,701**
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$ 144,658,811	$ 139,436,607	$ 110,808,111	$ 92,089,409	$ 76,294,959	
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$ 20,802,395	$ 32,867,029	$ 50,470,702	$ 56,618,450	$ 63,423,038	
Unused Title XXI Funds Expiring (Allotment or Reallocated)	$ 32,176,840	$ 27,513,467	$ -	$ -	$ -	
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$ 91,679,576	$ 79,056,111	$ 60,337,409	$ 35,470,959	$ 12,871,921	

*For SFY 00-01, the State claimed an additional $917,164 in previous years Marketing and Outreach costs that were allowable under the Federal Redistribution for FFY'98

Attachment I:
State Legislative Authority

Second Regular Session
Sixty-third General Assembly
STATE OF COLORADO

REREVISED

This Version Includes All Amendments Adopted in the Second House

LLS NO. 02-0421.01 Debbie Haskins **HOUSE BILL** 02-1155

HOUSE SPONSORSHIP

Clapp, Fairbank, Fritz, Hefley, Hoppe, Kester, Lawrence, Mace, Mitchell, Scott, Snook, Spence, Stafford, Swenson, Webster, White, and Witwer

SENATE SPONSORSHIP

Owen,

House Committees	**Senate Committees**
Health, Environment, Welfare, & Institutions	Health, Environment, Children & Families
Appropriations	Appropriations

A BILL FOR AN ACT

CONCERNING THE COVERAGE OF PREGNANT WOMEN UNDER THE CHILDREN'S BASIC HEALTH PLAN, AND MAKING AN APPROPRIATION THEREFOR.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Adds prenatal care and postpartum care to the children's basic health plan for pregnant women who are not eligible for medicaid. Covers pregnant women whose income is greater than the income level for the baby and kid care program (133% of the federal poverty level) up to the income level for the children's basic health plan (185% of the federal poverty level). Covers postpartum care for 60 days after the birth of the child. Provides that, upon birth, the child is automatically enrolled

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

SENATE 3rd Reading Unamended May 1, 2002

SENATE Amended 2nd Reading April 30, 2002

HOUSE 3rd Reading Unamended April 22, 2002

HOUSE Amended 2nd Reading April 19, 2002

in the children's basic health plan. Exempts a pregnant woman from paying the annual enrollment fee for the children's basic health plan.

Makes conforming amendments.

Makes an appropriation to implement the act.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 26-19-103 (4) and (5), Colorado Revised Statutes, are amended to read:

26-19-103. Definitions. As used in this article, unless the context otherwise requires:

(4) "Eligible person" means:

(a) A person who is less than nineteen years of age, whose family income does not exceed one hundred eighty-five percent of the federal poverty level, adjusted for family size; OR

(b) A PREGNANT WOMAN WHOSE FAMILY INCOME DOES NOT EXCEED ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL, ADJUSTED FOR FAMILY SIZE, AND WHO IS NOT ELIGIBLE FOR MEDICAID.

(5) "Enrollee" means any ~~child~~ ELIGIBLE PERSON that has enrolled in the plan.

SECTION 2. 26-19-104, Colorado Revised Statutes, is amended to read:

26-19-104. Children's basic health plan - rules. The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to ~~children~~ ELIGIBLE PERSONS on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative

Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

SECTION 3. 26-19-105 (2.5), Colorado Revised Statutes, is amended to read:

26-19-105. Trust - created. (2.5) For fiscal year 2000-01, the general assembly shall appropriate to the trust ten million dollars from the moneys received by the state for said fiscal year pursuant to the master settlement agreement. ~~Beginning in~~ FOR fiscal year 2001-02, ~~and for each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement,~~ the general assembly shall appropriate to the trust nine million eight hundred thousand dollars from the moneys annually received by the state pursuant to the master settlement agreement. BEGINNING IN FISCAL YEAR 2002-03, AND FOR EACH FISCAL YEAR THEREAFTER SO LONG AS THE STATE RECEIVES MONEYS PURSUANT TO THE MASTER SETTLEMENT AGREEMENT, THE GENERAL ASSEMBLY SHALL APPROPRIATE TO THE TRUST SEVENTEEN MILLION FIVE HUNDRED THOUSAND DOLLARS FROM THE MONEYS ANNUALLY RECEIVED BY THE STATE PURSUANT TO THE MASTER SETTLEMENT AGREEMENT. EXCEPT AS OTHERWISE PROVIDED IN SECTION 24-22-115.5, C.R.S., the general assembly shall appropriate the amount specified in this subsection (2.5) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S. The amount appropriated pursuant to this subsection (2.5) shall be in addition to and not in replacement of any general fund moneys appropriated to the trust.

SECTION 4. 26-19-107 (1) (a) (I) and (1) (b), Colorado Revised Statutes, are amended to read:

26-19-107. Duties of the department - schedule of services -

premiums - copayments - subsidies. (1) In addition to any other duties pursuant to this article, the department shall have the following duties:

(a) (I) To design, on or after April 21, 1998, and from time to time revise, a schedule of health care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, PRENATAL CARE AND POSTPARTUM CARE, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees. The department shall design and revise this schedule of health care services included in the plan to be based upon the basic and standard health benefit plans defined in section 10-16-102 (4) and (42), C.R.S.; except that the department may modify the basic and the standard health benefit plans to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

(b) To design and implement a system of cost-sharing with enrollees using an annual enrollment fee that is based on a sliding fee scale. The sliding fee scale shall be developed based on the enrollee's family income; except that no enrollment fee shall be assessed ~~to~~ against an enrollee whose family income is at or below one hundred fifty percent of the federal poverty level AND NO ENROLLMENT FEE SHALL BE ASSESSED AGAINST AN ENROLLEE WHO IS A PREGNANT WOMAN. As permitted by federal and state law, enrollees in the plan may use funds from a medical savings account to pay the annual enrollment fee. On or before November 1 of each year, the department shall submit for approval to the

joint budget committee its annual proposal for cost sharing for the plan based upon a family's income.

SECTION 5. 26-19-109, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

26-19-109. Eligibility - children - pregnant women. (5) (a) A PREGNANT WOMAN WHOSE FAMILY INCOME EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LEVEL BUT DOES NOT EXCEED ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL SHALL BE PRESUMPTIVELY ELIGIBLE FOR THE PLAN. ONCE DETERMINED ELIGIBLE FOR THE PLAN, A PREGNANT WOMAN SHALL BE CONSIDERED TO BE CONTINUOUSLY ELIGIBLE THROUGHOUT THE PREGNANCY AND FOR THE SIXTY DAYS FOLLOWING THE PREGNANCY, EVEN IF THE WOMAN'S ELIGIBILITY WOULD OTHERWISE TERMINATE DURING SUCH PERIOD DUE TO AN INCREASE IN INCOME. UPON BIRTH, A CHILD BORN TO A WOMAN ELIGIBLE FOR THE PLAN SHALL BE ELIGIBLE FOR THE PLAN AND SHALL BE AUTOMATICALLY ENROLLED IN THE PLAN IN ACCORDANCE WITH THE ELIGIBILITY REQUIREMENTS FOR CHILDREN SPECIFIED IN SUBSECTION (4) OF THIS SECTION.

(b) (I) UNDER THE PLAN, PRENATAL AND POSTPARTUM PRIMARY HEALTH CARE PROVIDERS SHALL IMPLEMENT POLICIES REGARDING THE INTEGRATION OF EVIDENCE-BASED TOBACCO USE TREATMENTS INTO THE REGULAR HEALTH CARE DELIVERY SYSTEM, INCLUDING, BUT NOT LIMITED TO:

(A) ASSESSMENT OF TOBACCO USE AND EXPOSURE TO SECOND-HAND SMOKE;

(B) EDUCATION ON THE DANGERS OF TOBACCO USE DURING PREGNANCY AND POSTPARTUM;

(C) REFERRALS TO APPROPRIATE CESSATION SERVICES.

(II) HEALTH CARE PROVIDERS MAY COORDINATE THE IMPLEMENTATION OF SUCH POLICIES WITH THE TOBACCO EDUCATION, PREVENTION, AND CESSATION PROGRAMS ESTABLISHED IN SECTION 25-3.5-804, C.R.S.

(c) THE ADDITION OF COVERAGE UNDER THE PLAN FOR PREGNANT WOMEN SHALL ONLY BE IMPLEMENTED IF THE DEPARTMENT OBTAINS A WAIVER FROM THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

SECTION 6. 26-19-110 (8), Colorado Revised Statutes, is amended to read:

26-19-110. Participation by managed care plans. (8) All managed care plans participating in the plan shall meet standards regarding the quality of services to be provided, financial integrity, and responsiveness to the unmet health care needs of ~~children~~ ELIGIBLE PERSONS that may be served.

SECTION 7. 24-22-115.5 (2), Colorado Revised Statutes, is amended to read:

24-22-115.5. Legislative declaration - tobacco litigation settlement trust fund - creation. (2) There is hereby created in the state treasury the tobacco litigation settlement trust fund. The principal of the trust fund shall consist of the first thirty-three million dollars of all moneys, other than attorney fees and costs, paid to the state treasurer in accordance with the terms of the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds*

Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.; Lorillard Tobacco Co., Inc.; Phillip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc., Case No. 97 CV 3432, in the district court for the city and county of Denver, not less than twenty-one percent of all additional moneys, other than attorney fees and costs, paid to the state treasurer in accordance with the settlement agreements and the consent decree, and any moneys transferred to the trust fund from the tobacco litigation settlement cash fund at the end of any fiscal year pursuant to section 24-22-115. The principal of the trust fund shall not be expended or appropriated for any purpose; EXCEPT THAT MONEYS IN THE TRUST FUND MAY BE ALLOCATED TO THE CHILDREN'S BASIC HEALTH PLAN TRUST AS PROVIDED IN SECTION 24-75-1104 (2). All interest derived from the deposit and investment of moneys in the trust fund shall be credited to the trust fund. Such interest shall become subject to appropriation by the general assembly for the funding of any programs or funds authorized by law to be funded by tobacco litigation settlement moneys at such time as the state auditor certifies that actuarially sound projections of future interest earnings indicate that such interest will be sufficient to fully fund such programs and funds. No part of such trust fund, principal or interest, shall be transferred to the general fund or any other fund or used or appropriated except as provided in this section.

SECTION 8. 24-75-1103 (4), Colorado Revised Statutes, is amended to read:

24-75-1103. Policy on use of tobacco settlement funds. (4) Since the amount of moneys to be received by the state is uncertain,

a portion of the settlement moneys shall be placed in an endowment trust fund created in section 24-22-115.5, with the principal and interest reinvested in the trust fund until the state auditor certifies that actuarially sound projections of future interest earnings indicate that the interest earned will be sufficient to fully fund the tobacco settlement programs. HOWEVER, NOTWITHSTANDING THE POLICY PROHIBITING THE APPROPRIATION OF THE PRINCIPAL IN THE TRUST FUND, THE PRINCIPAL MAY BE EXPENDED AS PROVIDED IN SECTION 24-22-115.5 (2).

SECTION 9. 24-75-1104 (1) (b) and (2), Colorado Revised Statutes, are amended to read:

24-75-1104. Use of settlement moneys - programs. (1) For the 2000-01 fiscal year and for each fiscal year thereafter, the following programs shall receive appropriations in the specified amounts from the settlement moneys annually received by the state:

(b) (I) FOR THE FISCAL YEAR 2001-02, the children's basic health plan trust created in section 26-19-105, C.R.S., shall receive nine million eight hundred thousand dollars;

(II) FOR THE FISCAL YEAR 2002-03 AND EACH FISCAL YEAR THEREAFTER, THE CHILDREN'S BASIC HEALTH PLAN TRUST CREATED IN SECTION 26-19-105, C.R.S., SHALL RECEIVE SEVENTEEN MILLION FIVE HUNDRED THOUSAND DOLLARS;

(2) The general assembly shall appropriate the amounts specified in subsection (1) of this section from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115. THE STATE CONTROLLER SHALL FIRST ALLOCATE THE AMOUNTS SPECIFIED IN PARAGRAPHS (a), (c), (d), (e), (f), AND (g) OF SUBSECTION (1) OF THIS SECTION AND THEN ALLOCATE THE AMOUNT FOR THE CHILDREN'S BASIC

HEALTH PLAN TRUST AS SPECIFIED IN PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION. IF THE MONEYS IN THE TOBACCO LITIGATION SETTLEMENT CASH FUND ARE INSUFFICIENT TO FUND THE FULL AMOUNT SPECIFIED IN SUBPARAGRAPH (II) OF SAID PARAGRAPH (b) FOR THE CHILDREN'S BASIC HEALTH PLAN TRUST, THE AMOUNT OF THE SHORTFALL SHALL BE ALLOCATED OUT OF THE TOBACCO LITIGATION SETTLEMENT TRUST FUND. Any amount of unencumbered settlement moneys remaining in the fund of any program specified in subsection (1) of this section at the end of any fiscal year shall be transferred to the tobacco litigation settlement trust fund created in section 24-22-115.5; except that unencumbered settlement moneys shall not be transferred from the following funds:

(a) The children's basic health plan trust created in section 26-19-105, C.R.S.;

(b) The read-to-achieve cash fund created pursuant to section 22-7-506, C.R.S.;

(c) The Colorado state veterans trust fund created in section 26-10-111, C.R.S.;

(d) The state dental loan repayment fund created in section 25-23-104, C.R.S.

SECTION 10. 24-75-1105 (1), Colorado Revised Statutes, is amended to read:

24-75-1105. Use of settlement moneys - review. (1) On or before January 30, 2006, the joint budget committee and the health, environment, welfare, and institutions committees of the general assembly, referred to in this section as the "joint committees", shall meet jointly to review the use of settlement moneys. Specifically, the joint

committees shall review:

(a) The effectiveness of each program that receives settlement moneys, including but not limited to reviewing the annual reports of each program prepared by the department of public health and environment pursuant to section 25-1-108.5, C.R.S., and the program reviews of each program prepared by the state auditor pursuant to section 2-3-113, C.R.S.;

(a.5) FOR THE CHILDREN'S BASIC HEALTH PLAN, ALL OF THE ITEMS LISTED IN THIS SUBSECTION (1) FOR REVIEW SHALL BE SEPARATELY REPORTED AND REVIEWED WITH RESPECT TO THE CHILDREN'S BASIC HEALTH PLAN AND THE PRENATAL AND POSTPARTUM CARE PROGRAM ADDED TO THE CHILDREN'S BASIC HEALTH PLAN IN FISCAL YEAR 2002-03. THE JOINT COMMITTEE SHALL ALSO CONSIDER WHETHER THE PRENATAL AND POSTPARTUM CARE PORTION OF THE CHILDREN'S BASIC HEALTH PLAN SHOULD CONTINUE TO BE PAID FOR OUT OF SETTLEMENT MONEYS OR SHOULD BE PAID FOR OUT OF GENERAL FUND REVENUES.

(b) The costs incurred by each program that receives settlement moneys, including but not limited to the amount and justification of administrative costs incurred by the agencies that implement the program;

(c) The percentage allocated to each program receiving settlement moneys and the actual amount appropriated to each program each fiscal year; and

(d) The amount of settlement moneys annually credited to the tobacco litigation settlement trust fund created in section 24-22-115.5, C.R.S., the investment of and return on such moneys, and the projections of future interest earnings on the moneys in the fund.

SECTION 11. Appropriation. (1) In addition to any other

appropriation, there is hereby appropriated, to the department of health care policy and financing, indigent care program, children's basic health plan trust, for the fiscal year beginning July 1, 2002, the sum of seven million seven hundred thousand dollars ($7,700,000), or so much thereof as may be necessary, for the implementation of this act. Said sum shall be from the tobacco litigation settlement cash fund created in section 24-22-115.5, Colorado Revised Statutes, pursuant to section 24-75-1104 (1) (b) (II), Colorado Revised Statutes.

(2) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, indigent care program, the sum of six million three hundred twenty-one thousand five hundred sixty-one dollars ($6,321,561). Said sum shall be from cash funds exempt from the children's basic health plan trust created in section 26-19-105, Colorado Revised Statutes. The moneys hereby appropriated shall be for the costs under section 26-19-109, Colorado Revised Statutes. In addition to said appropriation, the general assembly anticipates that, for the fiscal year beginning July 1, 2002, the department of health care policy and financing, indigent care program, will receive the sum of eleven million seven hundred forty thousand forty-four dollars ($11,740,044) in federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds.

(3) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, department of human services medicaid-funded programs, office of information technology services - medicaid funding, the sum of twenty-six thousand one hundred sixty-three dollars ($26,163). Said sum

shall be from cash funds exempt from the _____ children's basic health plan trust created in section 26-19-105, Colorado Revised Statutes. In addition to said appropriation, the general assembly anticipates that, for the fiscal year beginning July 1, 2002, the department of health care policy and financing, department of human services medicaid - funded programs, office of information technology services - medicaid funding, **will receive the sum of forty-eight thousand five hundred eighty-seven dollars ($48,587) in federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds.**

(4) In addition to any other appropriation, there is hereby appropriated, to the department of human services, office of information technology services, the sum of seventy-four thousand seven hundred fifty dollars ($74,750). Said sum shall be from cash funds exempt received from the department of health care policy and financing out of the appropriation made in subsection (3).

SECTION 12. Effective date. This act shall take effect upon passage; except that section 11 of this act shall take effect only if Senate Bill 02-062 does not become law.

SECTION 13. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.